Organizational status, ownership and regulation of hospitals – basics and situation in Europe

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Chapter 6: Regulating entrepreneurial behaviour in hospitals: theory and practice.
By Busse R, van der Grinten T, Svensson P-G.
Scenario 1

In an entrepreneur’s ideal world, one could set up a hospital, determine how to run it and be responsible for all losses and profit. The right to establish a hospital would include the **freedom to choose a location**, to determine the **size** and to decide on the **range of technology and services** offered. One could also decide whether services to deliver on an in- or out-patient basis, set **price levels** and **refuse to accept certain patients**.

Also, one had the right to decide on **staffing numbers** and **qualification mix**, the working conditions of the employees and their **salaries**.

Lastly, there would be no restrictions on business relationships with suppliers and other hospitals, including the right for **mergers** and horizontal and vertical **takeovers**.
Scenario 2

In the other end of the spectrum, the national government - or a subordinated public body such as a Health Authority - establishes hospitals where and at what size deemed necessary according to a public plan.

The **planning authorities determine** the technology installed and the range of services offered. Services are delivered free to all citizens at the point of service, hence no prices need to be set. Staffing and working conditions are decided by the public authorities and standard public salaries apply.

As the hospitals are part of the public health services infrastructure, they have no independent relationships with other actors and no room for mergers or takeovers.
Two types of “non-regulation“

Both hospitals are not regulated. In the first case, there are intentionally no regulations to restrict the market behaviour of the hospital owners and/or managers, in the latter case the hospital is subject to public sector ”command-and-control”. In practice, most hospitals in many countries fall somewhere between the two extremes and require more regulation than these two.
Adapted from „A Conceptual Framework for the Organizational Reform of Hospitals“ (Harding/ Preker, Worldbank)
<table>
<thead>
<tr>
<th></th>
<th>Core public bureaucracy</th>
<th>Private organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autonomy</strong></td>
<td>Few decision rights</td>
<td>Full autonomy</td>
</tr>
<tr>
<td><strong>Market exposure</strong></td>
<td>None</td>
<td>At full risk for performance</td>
</tr>
<tr>
<td><strong>Residual claimant</strong></td>
<td>Public purse</td>
<td>Organization</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td>Hierarchical direct control</td>
<td>Regulation and contracting</td>
</tr>
<tr>
<td><strong>Social functions</strong></td>
<td>Unfunded mandate</td>
<td>Explicitly funded mandate</td>
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</tbody>
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The diversity of hospital types in Europe

• insufficient and misleading traditional classification (e.g. in OECD database): public, private not-for-profit, private for profit

• public hospitals encompass wide range from “budgetary“ via „autonomous“ to „corporatized“

• public autonomous = private not-for-profit?

• what about “public enterprises“ with partly private ownership? In Germany now quite common.

• big differences between contracted and other private for-profit hospitals
Public-private ownership in Bismarckian countries (late 1990s)

<table>
<thead>
<tr>
<th>Country</th>
<th>Public</th>
<th>Not-for-profit</th>
<th>For profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>69%</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Belgium</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>65%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Germany</td>
<td>54%</td>
<td>38%</td>
<td>7%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>14%</td>
<td>86%</td>
<td></td>
</tr>
</tbody>
</table>

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Regulation requires autonomy and autonomy requires regulation

- The main emphasis of governments in many European countries has been on making hospitals autonomous (or even corporatized);
- but: road to autonomization varies widely
How do countries autonomize?

- purchaser-hospital (provider) split
- introduction of contractual relationships between purchasers and hospitals (like in Bismarckian systems)
- increase decision-latitud of hospital about services, staffing etc.
- increase financial autonomy (“residual claimant“ status)
Caveats

• autonomization may lead to greater control of hospitals by central government (UK)

• pursuing devolution (e.g. to regions) and hospital autonomization may be contradictory actions (e.g. if regional governments have other ideas)

• certain forms of corporatization (e.g. public enterprise with shares) may lead to full privatization, even if contrary to initial plans
Types of regulation by intention and impact

- Pro-competitive regulation that stimulates market opportunities
- Pro-competitive regulation that restricts individual market-driven behaviour
- Regulation restricting hospitals to achieve social objectives as access, social cohesion, public health/safety, quality, and sustainable financing
- Regulation without good reasons
Pro-competitive regulation that stimulates market opportunities

• Replace input-oriented budgets with contract-based performance-related reimbursement
• Allow retention of surplus/profit
• Allow patients to choose the hospital for treatment (with or without GP guidance)
• Let money follow patient choice of hospital
• EU regulations on free movement of services
Pro-competitive regulation that restricts individual market-driven behaviour

- Include case-mix adjusters into flexible reimbursement system (i.e. restrict cream-skimming)
- Restrict (horizontal) mergers and acquisitions of other hospitals
- Restrict (vertical) mergers, acquiring and operating other healthcare institutions
Regulation restricting hospitals to achieve social objectives

- Regulate minimum service hours
- Mandate delivery of services to everybody
- Make accreditation/ quality assurance/ health technology assessment mandatory
- Mandate the public disclosure of performance (“league tables”)”)
- Set uniform or maximum price/ reimbursement or regulate that it is done by self-governing actors
What are the objectives of regulation?

• To enable hospital care: establishment of hospitals, capacity and technology
• To specify and reward hospital services: access, types, quality and prices
• To protect hospital employees
• To steer the business behaviour of hospitals: e.g. mergers, financial reserves, advertisements
Enabling hospital care

- Planning of capacities, ex-ante (= before hospitals are built) or ex-post (= contracts for existing hospitals)
- Combining planning with money for investments
- “Certificate of need“ for high technology
Specifying and rewarding hospital services

• **Access:** disallow patient selection, mandate non-scheduled admissions, require physician staffing around the clock, allow patient choice

• **Types of services:** There may be a case to restrict certain ambulatory services if they can be delivered more efficiently outside hospitals.

• **Quality:** require accreditation, QA programmes, public disclosure of results (e.g. ranking lists)

• **Prices:** transparency and administrative ease are advantages of uniformly regulated prices but ...
Protecting hospital employees

• equal treatment, opportunities and pay for men and women (76/207/EEC and 75/117/EEC)
• right to part-time work (97/81/EC; 98/23/EC)
• safeguarding of employees’ rights in the event of transfers of undertaking, businesses or parts of businesses (77/187/EEC; 98/50/EC)
• working times (93/104/EC)
Steering the business behaviour of hospitals - the UK example

The UK-NHS has addressed this topic in a guidance titled “The operation of the NHS internal market: Local freedoms, national responsibilities”.

Besides the question of mergers, the guidance regulates the exit of providers as well as conduct concerning pricing and costing as well as collusive behaviour. Examples of collusive behaviour are given: price-fixing, market-sharing agreements, collusive provider tendering for contracts, lack of competition at the contract renewal stage, and unjustifiable purchaser support for inefficient units. The difficulties of detection are acknowledged, especially as providers may engage in tacit rather than overt collusion. The penalties for collusion are cancellation of the contracts and ”management action”.